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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Afghanistan

SUMMARY

The Executive Director recommends that the Executive Board approve:

(a) The country programme of Afghanistan for the period 1996 to 1999 in the amount of $24,000,000 from general resources, subject to the availability of funds, and $28,000,000 in supplementary funds, subject to the availability of specific-purpose contributions;

(b) Additional general resources in the amount of $500,000 to fund the approved country programme for the period 1995 for which the balance of approved general resources is not sufficient to fund the programme up to the approved programme period.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. Since 1979, the effects of war and civil conflict have caused the deaths of over 1 million people in Afghanistan. In addition, over 2.5 million people have been injured or disabled, some 6 million have been forced to flee as refugees and some 2 million more have been displaced internally. Over 500,000 women have been widowed. The nation's economy and infrastructure are in ruins.

2. Much has changed since the beginning of 1992, when the Kabul Government controlled major cities, and liberation movements, supported by cross-border operations, controlled rural areas. At that time, the country received extensive international assistance for both war and social services. Since then, the Kabul Government has fallen and the capital has been largely destroyed, with more than one half of its population displaced. International assistance has declined precipitously. Refugees are placed under pressure to return home, where they face uncertain security and employment and an absence of basic services.

3. A six-month relative lull in fighting was broken in and around Kabul in January 1994, with heavy loss of life and destruction continuing throughout the year in the capital and areas along its access routes. Elsewhere, the widespread fighting, which had erupted in 1992, largely ceased by mid-1994, with rival factions trying to resolve disputes. In major cities such as Herat, Mazar-i-Sharif and Jalalabad, populations have swelled, municipal and provincial administrations are being re-established and attempts are being made to re-establish services regionally.

4. Most Afghans live in poverty and insecurity. Accidents from land-mines remain frequent, especially affecting children. De-mining activities are under way in many areas, but it will take many years to clear one of the most heavily mined and unmapped landscapes in the world. Resources are limited for rebuilding and buying seeds, fertilizers, and tools. Roadblocks by commanders keep marketing of agricultural produce a mostly local affair. Even so, Afghans are trying to rebuild their homes and lives.

5. The present situation weighs especially heavily on the hopes and opportunities of women. Traditionally, an Afghan woman cares for an average of six children in addition to working in the fields. She seldom leaves the house or farm unless accompanied by her husband or another male family member. She is most likely illiterate and ignorant of basic preventive health practices. She is at risk from one of the highest maternal mortality rates in the world. Refugee movement and displacement during the past 15 years have exposed many Afghan women to knowledge beyond their village, awakening aspirations to education, employment and basic health services.

6. The woman who hopes to better her lot also knows that she must proceed with care. The war has brought a backlash against changes in women's status. The breakdown of civil order has resulted in new restrictions on women's mobility, arising as much from genuine fears for their security as from the traditional safeguarding of family honour. However, especially in urban areas, intense economic pressures on family survival increasingly offset the pressures which keep women at home. The traditional systems for the care of women by surviving male family members are under strain. Scarcity of jobs, delays in payment of salaries and inflation are creating pressures for women to earn income.

7. The situation of Afghan women and children has always been among the worst in the world. During the war years, perhaps 10 times as many children died from malnutrition and disease as from war-related causes. In 1993, the infant mortality rate was estimated at 165 per 1,000 live births, and the under-five mortality rate was estimated at 257 per 1,000 live births. Life expectancy at birth was estimated at 45 years. Maternal mortality was 640 per 100,000 live

births, with 99 per cent of births at home and only 9 per cent attended by trained personnel. Some 20 per cent of babies were born with low birth weight, and malnutrition in children under five years of age was above 20 per cent. Adult literacy was estimated at 29 per cent, but only 14 per cent for females. According to 1989 data, gross primary school enrolment was 32 per cent for boys and 17 per cent for girls, with subsequent declines following the collapse of services in the urban areas. In urban areas, access to safe water supplies was 40 per cent, in rural areas, 19 per cent.

8. In 1993 alone, over 279,000 children under five years of age may have died. For children under one year of age, estimated mortality from neonatal tetanus is over 40 deaths per 1,000 live births, and mortality from measles, diarrhoea and respiratory infections totals 100 per 1,000 live births. There is great demand for vaccination, basic health services, health education and schools for children, including girls. But governance is weak and without resources to respond to those demands.

9. There is among Afghans a concern that the world that generously supported them in a time of war is now abandoning them and their children. Afghans are looking for partners for the long journey ahead.

PROGRAMME COOPERATION, 1992-1995

10. The objectives of UNICEF cooperation, which includes the programme approved by the Executive Board in 1992 for the period 1992-1994 (E/ICEF/1992/P/L.23) and the one-year short-duration programme approved by the Board in 1994 for 1995 (E/ICEF/1994/P/L.22), have been to promote child survival, meet emergency relief needs, assist children and women in especially difficult circumstances and support the rehabilitation of essential services.

11. UNICEF moved its country office support functions to Peshawar, Pakistan, in 1992. Emergency assistance coordinated from Peshawar is delivered from Kabul and from other regional sub-offices. UNICEF work expanded in Kabul when international staff returned during the second half of 1993, but was constrained in 1994 by the imposition of a military blockade on supplies. Activities in the western provinces have been extensive since early 1993. In the northern provinces, wide-scale activities in 1993, affected by fighting in early 1994, have expanded again. Deliveries to northern and north-eastern provinces are supported through other field stations. Deliveries to the south-east were reduced significantly, after security problems April 1993, to be expanded only in 1995. International staff, withdrawn from Jalalabad and the eastern provinces following the murder of four United Nations and non-governmental organization (NGO) staff there in February 1993, returned in January 1994 in response to an influx of several hundred thousand displaced persons from Kabul. Through work from these regional bases, UNICEF has gathered experience and established credibility upon which to build future programmes.

Health

12. The expanded programme on immunization (EPI) was implemented in urban areas through government vaccinators, and in rural areas, mostly through NGOs. UNICEF brought the NGOs under a common policy umbrella, focusing on the vaccination of children under two years of age and the tetanus toxoid vaccination of women 15 to 45 years old and school girls. In 1993, some 450,000 children under two years of age were vaccinated against measles and received vitamin A supplements, while coverage with the anti-tuberculosis vaccine was 500,000 (46 per cent of children under two years of age). Approximately 250,000 children under two years of age received the third dose of combined diphtheria/pertussis/tetanus vaccine and three doses of oral poliomyelitis vaccine, and 330,000 women received the second dose of tetanus toxoid vaccine. Reductions in donor funding

to NGOs affected several NGOs whose activities included EPI, and other NGOs faced increasing logistical constraints on cross-border operations. Government EPI activities in urban areas were affected by the collapse of government services.

13. In 1994, UNICEF, in consultation with the Ministry of Public Health, donors and NGOs, reorganized EPI to operate from regional centres. District-level activities are replacing the reliance of NGOs on mobile teams supported from cross-border bases.

14. Emergency health assistance included the provision of repairs, supplies and equipment for services disrupted by conflict, including the rehabilitation of 18 hospitals and 37 health centres in Kabul, Mazar, Herat, Jalalabad, Faizabad, Bamyan and Kandahar; the provision of medical supplies for hospitals and clinics in 23 provinces; and the provision of 270 metric tons of diesel fuel for hospitals in 1993/1994. Medical supplies were provided for camps in Jalalabad and Mazar serving over 150,000 displaced people. Mini health centres were set up in 45 locations in Kabul for oral rehydration therapy (ORT), the treatment of acute respiratory infections (ARI), nutrition screening and chlorine distribution to disinfect household wells. Eight mobile clinics operated in Mazar for similar activities.

15. The Government oral rehydration salts (ORS) production facility in Kabul was destroyed in 1993. Imported ORS sachets were supplied to health facilities and through commercial pharmacies in Mazar-i-Sharif and Herat. In 1993 and 1994, UNICEF supplied drugs, ORS, infusions and other assistance to establish cholera treatment units, and supported the chlorination of over 60,000 wells in Kabul. Health training and education focused on the control of diarrhoeal diseases, with 131 doctors and nurses trained. Maternal and child health (MCH) training covered 339 medical staff, 65 traditional birth attendance (TBAs), 40 community health volunteers and 268 teachers and community leaders. UNICEF also supported a British Broadcasting Corporation educational radio drama, broadcast in Dari and Pashto languages, which incorporates child survival and development issues.

Nutrition

16. Emergency nutrition activities focused on displaced and refugee populations in 11 provinces, including feeding programmes at kindergartens, day-care centres, orphanages and drop-in centres. K-mix II, a specially formulated mixture for the treatment of kwashiorkor, was provided for feeding centres run by NGOs, along with high-protein rations for malnourished children and lactating mothers identified through nutrition screening and outreach activities in the cities. In the area of children in especially difficult circumstances (CEDC), 720 street children were assisted through three drop-in centres. NGOs working with 420 children also were assisted.

Water supply, environment and sanitation

17. Activities in water supply and sanitation focused on hospitals, clinics, schools, children's institutions and displaced populations in urban and peri-urban areas in 12 provinces. From 1992 until October 1994, UNICEF supported the installation of 762 hand-pumps and the repair of 807 hand-pumps; the drilling of 299 semi-deep wells and 18 deep wells; and the installation of 18.5 kilometres of piping for 170 public standposts. The water systems of major hospitals were repaired in Kabul, Mazar, Herat and Jalalabad. Over 600 latrines were constructed for schools and health clinics. New drilling rigs were provided to Ministry of Reconstruction and Rural Development teams in Kabul, Mazar and Herat, along with in-service training for 161 technicians, engineers, mechanics and surveyors. Cooperation with Swedish, Danish and Norwegian NGOs supported rural water supply activities. UNICEF also assisted water supply

activities by seven NGOs and the construction of 15,000 latrines for 150,000 displaced persons in camps near Jalalabad.

Education

18. Fighting and displacement reduced children's school attendance in Kabul and Mazar. UNICEF provided basic supplies, including kits for the production of teaching aids, for 15,000 classrooms. UNICEF has printed messages from Facts for Life on the covers of exercise books for 150,000 students, a prelude to pilot child-to-child activities.

19. Vocational training was interrupted in 1992 by the fall of the Government. However, sewing projects for 300 women in Herat and 100 women in Mazar got under way in 1994, and the participants have begun to discuss their problems and organize to improve their own situation.

Emergency relief

20. Emergency relief assistance included the provision of blankets and tarpaulins for displaced women and children. Emergency activities and appeals are coordinated under the United Nations Office for the Coordination of Humanitarian Assistance to Afghanistan (UNOCHA), based in Islamabad. UNOCHA manages fund-raising and coordination for mine clearance and awareness activities. UNICEF emergency operations include a radio and communications system, the costs of United Nations security coordination and the costs of operating a United Nations air transportation network. Security is overseen by the United Nations Development Programme Resident Representative based in Islamabad. Weekly security and United Nations inter-agency meetings provide a forum for sharing of information and coordination, and ad hoc working groups are convened to deal with specific problems. At regional levels within Afghanistan, there are similar arrangements for local coordination and maintaining close relations with NGOs.

Lessons learned

21. A 1992 study of social communication among Afghan women highlighted their lack of formal education and access to information. Customs limit their contacts to a very small immediate circle of related women and men. Communication initiatives are needed to bring information and skills to at least one woman in each of these small circles, as well as to reach influential men who are the "gatekeepers" of information that reaches women. With literacy rates declining and few resources, innovative, community-based approaches will be needed to expand non-formal and basic education opportunities for girls and women.

22. UNICEF, the Ministry of Public Health, major NGOs, key donors and the World Health Organization (WHO) developed a regional framework for the coordination of primary health care (PHC) and to optimize the impact of limited resources. This minimum PHC framework should strengthen regional coordination capacities, reduce competition and the overlap of services provided by NGOs, and strengthen the regional management of PHC. The country programme of cooperation proposed for the 1996-1999 period reflects that framework.

23. Past cooperation expanded access to safe water supplies for about 500,000 persons. When measured against population growth during the three years (1992-1994), this would barely maintain current low rates of access to safe water supplies. Progress towards the World Summit for Children goal of universal access to safe drinking water will require more community involvement and resource generation, education to increase demand, and sustainable approaches for communities, local authorities and the private sector.

24. CEDC activities reached only small numbers of children and carried a high cost per beneficiary in a country where nearly all children are in especially difficult circumstances. The new programme needs to integrate CEDC initiatives into all the programme thrusts. In particular, emergency nutrition activities have left untouched root problems such as the late introduction of supplementary foods and other infant and child-care practices that need to be addressed by the education and mobilization of women.

25. The situation of the population in Afghanistan is as bad as or worse than that of displaced populations residing in internationally-assisted camps. Resource allocations that favour immediate emergency needs tend to reward areas with continuing conflicts at the expense of those trying to rebuild for the longer term. Emergency assistance also may encourage a mentality of dependency because of indiscriminate assistance in the past. The new country programme needs to balance longer-term programmes with emergency activities so that emergency activities do not detract from longer-term goals for children.

26. Improving the situation of Afghan children and women can build upon positive aspects of the country's culture, values and experience - strong family structures, the emergence of leadership and Afghan pride. Region by region, building relationships with local authorities can expand possibilities for action by and for women and address longer-term rehabilitation and development priorities for Afghanistan's women and children.

Country programme preparation process

27. The United Nations Rehabilitation Strategy for Afghanistan was developed by the United Nations and representatives of the Government of Afghanistan during 1993 and provides a general framework of programming priorities. The reorganization of EPI and the development of the minimum PHC framework in 1994 with government officials, WHO, NGOs and donors led to health programme proposals suitable for country-wide implementation wherever security conditions allow. A similar group covered education. For other sectors, UNICEF, during the period 1993-1994, began to explore frameworks for women's development, education and water supply and sanitation, and linkages between these frameworks. In some cases, consultations were held with regional and local authorities and NGOs.

RECOMMENDATION FOR ADDITIONAL GENERAL RESOURCES FOR THE APPROVED COUNTRY PROGRAMME, 1995

Annual funding requirements
(In thousands of United States dollars)

Current programme cycle	Approved general resources funding a/	Additional funding proposed 1995
1995	5 500	500

a/ The amount shown here includes the actual balance carried over from the previous programme cycle.

28. The Afghanistan short-duration programme of cooperation for the period 1995 was approved by the Executive Board in 1994, with an allocation of $5,500,000 from general resources (E/ICEF/1994/P/L.22). Based on the availability of additional general resources and opportunities for the acceleration of programme implementation towards the reestablishment of basic services in peaceful areas, the annual ceiling of the country programme was increased by $500,000 in 1995. Consequently, the Executive Board is requested to approve additional general resources in the amount of $500,000 for 1995 to fund the programme up to the new approved ceiling.

29. Fighting in Kabul throughout most of 1994 displaced over 500,000 inhabitants who fled into neighbouring provinces and necessitated the creation of large camps for displaced families in Jalalabad (eastern region). Despite such set-backs to normalization in the capital and the need for a major emergency response to meet the needs of the displaced, many other parts of the country were peaceful, and local leadership (shouras) began efforts to re-establish basic services, especially in health and education. UNICEF worked closely with potential counterparts in those areas, and in 1994 began regionalizing management and cold-chain arrangements for its EPI and other PHC support. UNICEF also provided support for Afghan health authorities to implement a mass immunization campaign in November 1994. Public response was overwhelming, and such campaigns will be expanded in 1995. In 1995, UNICEF will strengthen regional programme development and implementation capacities, in order to be able to support rehabilitation in peaceful areas; to develop pilot programme activities to support communities' efforts in education and women's programmes; and to strengthen advocacy for children and women among emerging local leadership and counterpart institutions. The additional general resources of $500,000 will be used to strengthen staffing in existing programme bases and to establish new outreach bases for these activities.

RECOMMENDED PROGRAMME COOPERATION, 1996-1999

General resources : $24,000,000
Supplementary funding: $28,000,000

Recommended programme expenditures a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	9 820	14 585	24 405
Community education and development	5 940	9 460	15 400
Planning, advocacy and communication	1 780	1 605	3 385
Emergency response and rehabilitation	660	850	1 510
Programme support	5 800	1 500	7 300
Total	24 000	28 000	52 000

a/ The breakdown for estimated yearly expenditures and sectors is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme goals and objectives

30. Afghanistan has signed the Declaration of the World Summit for Children and has ratified the Convention on the Rights of the Child, but presently there is no central government capacity or resources for follow-up on implementation. The goal of the country programme is to use a regionally-based strategy to create a favourable environment for Afghanistan's pursuit of the goals of the World Summit for Children and for implementing the Convention on the Rights of the Child. A relatively more immediate overall objective is to empower Afghan communities to enhance the quality of life of women and children, and through them, of their families.

31. Specific objectives of the country programme include (a) to provide support for basic services to reduce the high mortality rates for children under five years of age and mothers; (b) to mobilize communities to provide basic education, especially for girls, and resources to achieve universal primary education; (c) to encourage and support communities' initiatives to strengthen women's capacities to contribute to family and social development; (d) to develop appropriate models and initiate community action to reduce water-borne and hygiene-related diseases; and (e) to strengthen forces in society favourable to enhancing the rights of the child.

Coverage

32. Communication and health activities will be implemented country-wide. Where local receptivity and security conditions will allow, at least one PHC facility will be supported in each district for EPI, essential drugs and training volunteer health sisters for health education activities. For education, water supply and sanitation and women's development, the target is to establish activities in at least one district of every province, as a basis for universal coverage. The scope of coverage for all programmes will depend on community receptivity, the availability of external resources and the security conditions. Emergency activities will continue in response to crises that threaten the immediate survival of women and children, especially in locations where the political and security situation does not allow rehabilitation and development activities.

Strategies

33. The activities for planning, advocacy and communication will cut across all programmes, focusing on advocacy, resource generation and the promotion of key messages through mass media related to the community's responsibility to address the needs of women and children. Planning activities will identify entry points to mobilize communities for the formulation and monitoring of area-based plans of action for children. In essence, planning activities will help to establish capacity and regional constituencies for future initiation of a national programme of action (NPA) for children that will respond to the World Summit goals.

34. A nation-wide service delivery strategy will focus on the achievement of universal child immunization as a basis to expand access to ORT, vitamin A and the control and treatment of ARI, and to promote the use of iodized salt. UNICEF support to NGOs and local governments will introduce a payment-for-service system for curative care and essential drugs. This should generate resources to cover operational costs and to establish traditions of local management. Community involvement in health and nutrition activities will have a strong focus on antenatal nutrition, reducing growth faltering in children aged six months to two years and improving practices for safe births and newborn care during home deliveries.

35. Area-based projects will explore the scope for community initiatives in education, women's activities and water supply, sanitation and hygiene. As related to achievement of the relevant goals of the World Summit for Children, strategies will emphasize community empowerment, i.e., mobilizing communities to better understand their own needs and to generate resources to address them. Selection of priorities will be decentralized and responsive to local needs and to opportunities and partnerships with communities and NGOs. For women's activities, advocacy will focus on gaining acceptance by men. The grouping of women's development activities in the same programme cluster with education and water supply activities will link assistance in the latter areas, much in demand by communities, to entry points to assist women. Close linkages to activities in health also will provide entry points for community action, and, in turn, strengthen community support for the health services. The involvement of regional and provincial government and NGO institutions will help to develop their capacities to replicate successes on a wider scale.

36. Emergency activities will be implemented under a separate programme, funded largely from supplementary funds and appeals, and implemented in close coordination with other United Nations agencies. External funding will need to be mobilized quickly should major emergencies arise to minimize the diversion of resources and personnel from the regular programme activities in peaceful zones. Material assistance will be complemented by community organization and education activities, as well as activities to strengthen local capacities to respond to emergencies.

Planning, advocacy and communication

37. The planning, advocacy and communication programme seeks to increase the motivation and capacity of Afghanistan's leadership and communities to address the needs of women and children. An initiative on women and children in Islam will support publications and seminars for Afghan religious leaders on Islamic thought regarding children and women, for example, information on health, hygiene and child care. A project on "children first" will publicize the goals of the World Summit for Children, the Convention on the Rights of the Child and how country programme activities relate to them. A project on mass media support for women and children will continue assistance for a radio drama and related activities in the print media, radio and other television broadcasts.

38. A communication support project will facilitate cross-sectoral coordination and implementation of communication activities within the country programme, including training for relevant government and NGO personnel; the development of distance learning activities to support health, education and water supply and sanitation programmes; and monitoring and evaluating the effectiveness of communication activities in all programmes.

39. A project on planning for women and children will develop advocacy activities and strategies for mobilizing communities to implement activities for children and women; introduce Afghan communities to methods of assessment, analysis and action for children; and increase capacities of regional and provincial authorities and NGOs to implement this model on a wider scale. Mid-term reviews, country programme preparation and monitoring and evaluation activities related to achieving World Summit goals also will be supported.

Health and nutrition

40. The objectives of the health and nutrition programme are to reduce morbidity and mortality among children under five years of age and to reduce maternal mortality. The strategy is to rebuild a service delivery system for PHC/MCH services for at least 60 per cent of the population. EPI and related activities will be instituted in at least one facility in each of Afghanistan's 328 districts. Assistance and monitoring will be managed by UNICEF sub-offices,

as well as by regional and provincial government and NGO personnel seconded to regional management teams. The coverage target is 80 per cent of infants through fixed-point outreach strategies and periodic measles and polio vaccination campaigns. Up to three doses of tetanus toxoid vaccine will be provided for mothers of the children who are vaccinated, and also through campaigns to reach newly-wed women. The EPI management, logistics and supervision system also will manage expansion of community-based education and services related to the control of ARI, vitamin A distribution and increasing the use of ORT to 80 per cent. Consequently, this component is called EPI Plus.

41. A project on the management of PHC/MCH services will strengthen government capacity at regional and provincial levels and support Ministry of Public Health efforts to increase the competency of managerial personnel. Regional management teams will train health personnel in micro-planning, management and supervisory skills in an effort to improve the coordination of health education and community mobilization activities, to develop regional training capacities and to strengthen information and monitoring systems. The regional management teams also will implement a project on community essential drugs to enhance basic curative care so that basic drugs are accessible and used appropriately. A Bamako Initiative approach will be introduced, using community resources for preventive care.

42. Regional management groups will train health workers on key MCH topics and prepare them to train TBAs and volunteer health sisters to implement improved antenatal and home delivery practices. In coordination with area-based women's projects, women's access to health and family planning services will be expanded. Improving care for obstetric emergencies will be a priority in assistance for rehabilitation of health institutions.

43. A nutrition project will assess the nutrition status of Afghan children and identify interventions to reduce growth faltering in children under two years of age. Activities will include the promotion of breast-feeding and timely supplementation, and "child feeding circles" as part of women's projects. Other activities will include assessments of antenatal nutrition; interventions to reduce micronutrient deficiencies; and the development of appropriate messages, for men and women, regarding women's dietary needs. A separate iodine deficiency disorders initiative will iodize salt being produced in three major salt production facilities and promote the consumption of iodized salt.

Community education and development

44. The programme will be implemented through seven area-based projects. Activities will relate to basic education, women's organization and action, and water supply, sanitation and hygiene. The objectives are to mobilize community support and resources for basic education, especially girls education; to increase women's opportunities and potential to contribute to family and social development; and to strengthen community capacities to reduce the incidence and effects of water-borne and hygiene-related diseases.

45. Activities will help communities to commit themselves and their own resources to achieving World Summit goals for basic education, water supply, sanitation and nutrition. Specific community education and development activities will be determined at regional and provincial levels by UNICEF and local governments through consultation and experimentation with communities. Initial contacts with communities will be linked with activities under the health and nutrition programme.

46. UNICEF will support the development of appropriate designs for community construction and the mobilization of resources for school buildings and rehabilitation. Local authorities, teachers and communities also will be supported to improve the quality of education activities through training on

Facts for Life and child-to-child messages, trauma recognition and intervention, and the promotion of peace and activities to encourage the enrolment and retention of girls. Other initiatives may include learning opportunities for older, out-of-school children denied education by war, and support for female teacher training, distance learning, or other approaches to increase primary education for girls.

47. Objectives related to organization and action for women are to strengthen community resolve and capacity to deal with the problems of women, especially widows. The strategy emphasizes action by women to promote communication among women on essential information, especially for widows and parents of children in especially difficult circumstances. Raising community consciousness about women's needs requires support from men, as well as support to form women's groups. Such groups would focus on concrete action acceptable to the community, such as the organization of child feeding groups to correct and prevent undernutrition; health education as an entry point for non-formal education; income generation, especially for widows; and communal child care and credit for working women.

48. Water supply, sanitation and hygiene activities will seek to mobilize communities and enhance their capacities to achieve access to safe water supplies and sanitation. Locally appropriate technologies will be emphasized, including the improvement and protection of current water sources; private sector initiatives; and education to improve water use, sanitation and hygiene. UNICEF support also will provide water supplies and sanitation for schools as an entry point for community education and action. Provincial and regional authorities, such as local departments of the Ministry of Reconstruction and Rural Development and NGOs, will be assisted to strengthen their capacities to support community initiatives, including information and monitoring systems.

49. The target is to develop at least one district-level initiative in each of seven regions by 1997, for 140,000 persons. A mid-term review will identify activities for more widespread replication, with a focus, in the second two years of the programme, on capacity-building for local authorities in each province.

Emergency response and rehabilitation

50. The objective is to respond to the emergency survival needs of women and children and to increase local self-reliance to meet those needs. Emergency activities will be implemented with emergency funding. UNICEF programme staff will support initial emergency assessment and response, but the country office will rely on regional and headquarters support for fund-raising and for the recruitment and quick assignment of short-term personnel.

51. As the emergency declines, refugees will return and overstrain local capacities. Emergency service delivery also will be needed should earthquakes, floods, landslides or other disasters threaten. Activities will include prepositioning of essential supplies in emergency-prone areas where snow, floods or other conditions would prevent seasonal access. UNICEF assistance for emergency responses could include medical supplies, water supply and sanitation, educational supplies, rebuilding of schools and emergency food rations for young children.

52. An additional objective is to strengthen regional capacities to meet the demands of emergencies. This would enhance regional preparedness to assess and respond to emergencies and improve coordination and contingency planning with local agencies and institutions. An implementation framework for ensuring that women's needs and perspectives are taken into account in emergency assessments and responses also would be developed.

Monitoring and evaluation

53. Statistics systems are virtually non-existent. As long as the conflict is widespread, large-scale sample surveys are not feasible, although local studies are possible where cooperation has established trust. In this context, data collection for the country programme will be built into project initiatives.

54. The PHC/MCH management support project will establish monitoring and analysis capacities at regional levels. EPI cluster surveys in selected localities will complement the information system and collect data on additional indicators related to communication and access to education, water supply and sanitation. UNICEF also will support experiments, such as the use of networks of mullahs to collect mortality statistics and other data related to the goals of the World Summit for Children.

55. Regional plans of action for children will be developed with local authorities and communities. There will be annual reviews of programme activities with regional officials and United Nations and NGO partners.

56. A mid-term evaluation in 1997 will assess progress and, where possible, focus future activities on a wide-scale replication of successful community initiatives. As soon as the present conflicts are resolved, UNICEF will work with the Government, other United Nations agencies and national NGOs to develop an NPA.

Programme management and coordination

57. Programme support includes staff costs; office operational costs, including sub-offices and field stations; use of United Nations aircraft and joint security arrangements; and operation of radio communication systems with field offices. For the 1996-1997 period, most of these costs will be allocated to general resources, until supplementary funding becomes available.

58. The role of subnational programming should be enhanced. A senior international staff presence remains necessary in major sub-offices. National staff should be strengthened in programme development and delivery capacity. More female staff would bring perspectives on the needs of Afghan women and enhance the UNICEF role in advocacy for Afghan women and children.

59. The country office was temporarily relocated from Kabul to Peshawar, Pakistan, for security reasons. Operational, supply and field support functions are being managed from Peshawar until conditions in Kabul allow a return of all staff. Programme staff based in Peshawar will spend about 60 per cent of their time in the sub-offices. International programme officers for education and for water supply and sanitation also will be outposted to sub-offices pending their return to Kabul. The Kabul office remains open as one of seven regional sub-offices. Provincial field outstations, supported by the regional sub-offices, will operate in at least six additional sites in 1996 to provide outreach to communities where adequate government channels do not exist.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Afghanistan	(1992 and earlier years)		UNICEF country classification
Under-five mortality rate	257	(1993)	Very high U5MR
Infant mortality rate	165	(1993)	Very high IMR
GNP per capita	$ 280	(1987)	Low-income GNP
Total population	20.6 million	(1993)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1993
Births	(thousands)	718	778	894	1086
Infant deaths (under 1)	(thousands)	142	142	149	179
Under-five deaths	(thousands)	230	218	232	279
Under-five mortality rate (per 1,000 live births)		320	280	260	257
Infant mortality rate (under 1) (per 1,000 live births)		198	183	167	165

		About 1980	Most recent
Underweight children (under 5) (% weight for age)	Moderate & severe	..	..
	Severe	..	..
Babies with low birth weight (%, 1979/1987)		20	20
Primary school children reaching grade 5 (%, 1980/1989)		62	43

NUTRITION INDICATORS	About 1980	Most recent
Exclusive breast-feeding rate (<4 mos.) (%)	..	..
Timely complementary feeding rate (6-9 mos.) (%)	..	..
Continued breast-feeding rate (20-23 mos.) (%)	..	..
Prevalence of wasting (0-59 mos.) (%)	..	..
Prevalence of stunting (0-59 mos.) (%)	..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1988-1990)	94	72
Total goitre rate	..	20
Household expenditure (% of total income) All food/cereals	..	.. / ..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1986/1992)		26	26
Access to health services	Total	..	29
(% of population, 1985)	Urban/rural	.. / ..	80 / 17
Access to safe water	Total	11	23
(% of population, 1980/1990)	Urban/rural	28 / 8	40 / 19
Access to adequate sanitation	Total	..	..
(% of population, 1985/1990)	Urban/rural	5 / ..	13 / ..
Births attended by trained personnel (%, 1989)			9
Maternal mortality rate (per 100,000 live births, 1989)		..	640

Immunization		1981	1985	1990	1993
One-year-olds (%) immunized against:	Tuberculosis	8	17	30	60
	DPT	3	15	25	34
	Polio	3	15	25	34
	Measles	6	14	20	42
Pregnant women (%) immunized against:	Tetanus	3	11	3	9

TABLE 1 (continued)

Afghanistan

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1989)	Total	34 / 29	24 / ..
	Male	54 / 46	32 / ..
	Female	12 / 11	17 / ..
Secondary enrolment ratio (gross/net) (%, 1980/1989)	Total	10 / ..	8 / ..
	Male	16 / ..	.. / ..
	Female	4 / ..	.. / ..
Adult literacy rate, 15 years & older (%, 1979/1990)	Total	18	29
	Male/female	30 / 5	44 / 14
Radio/television sets (per 1,000 population, 1980/1991)		75 / 3	107 / 8

DEMOGRAPHIC INDICATORS		1970	1980	1990	1993	2000
Total population	(thousands)	13623	16063	16556	20547	26767
Population aged 0-15 years	(thousands)	6114	7262	7304	8650	12026
Population aged 0-4 years	(thousands)	2482	2650	2963	3744	4879
Urban population (% of total)		11.0	15.6	18.2	19.4	22.2
Life expectancy at birth (years)	Total	37	40	42	44	46
	Male	37	40	42	43	46
	Female	37	41	43	44	47
Total fertility rate		7.1	7.1	6.9	6.8	6.1
Crude birth rate (per 1,000 population)		52	50	51	52	45
Crude death rate (per 1,000 population)		27	24	23	22	19

		About 1980	Most recent
Contraceptive prevalence rate (%, 1976)		2.0	..
Population annual growth rate (%, 1965-1980/1980-1993)	Total	1.9	1.9
	Urban	5.3	3.6

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980)		0.6	..
Inflation rate (%)		..	..
Population in absolute poverty (%, 1977)	Urban/rural	18 / 36	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure (% of total expenditure)	Health/education	.. / ..	.. / ..
	Defence	..	..
Household expenditure (% share of total, 1980 or 1985)	Health/education	.. / ..	.. / ..
Official development assistance: (1981/1992)	$US millions	23	174
	As % of GNP	1	..
Debt service (% of goods and services exports)		..	..

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1992-1995 a/

COUNTRY: AFGHANISTAN
LATEST BOARD APPROVAL: 1994
GENERAL RESOURCES: $22 000 000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health										9 350		8 760		18 110
Nutrition										950		480		1 430
Water supply and sanitation										2 000		6 260		8 260
Education										1 900		1 750		3 650
Women-centred programme										950		1 200		2 150
Children in especially difficult circumstances										1 000		1 250		2 250
Programme support										3 750				3 750
Emergency	6 887	6 097			4 110	958	4 041	928	15 038	2 100	7 983	1 200	23 021	3 300
GRAND TOTAL	6 887	6 097			4 110	958	4 041	928	15 038	22 000 b/	7 983	20 900 c/	23 021	42 900

GR = General resources.
FSF = Programmes approved for funded supplementary funding.
SF = Programmes for supplementary funding, funded and unfunded.

a/ Actual expenditures include expenditures recorded as of December 1994.

b/ Includes general resources for the 1992-1994 programme (E/ICEF/1992/P/L.23) and a one-year extension programme for 1995 (E/ICEF/1994/P/L.22).

c/ Of this amount, $7 000 000 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1996 - 1999

(In thousands of United States dollars)

Country: AFGHANISTAN **Period covered: 1996 - 1999**	**Funding status**	**1996**	**1997**	**1998**	**1999**	**Total**
Health and nutrition	GR	2 470	2 450	2 450	2 450	9 820
	NSF	3 425	3 460	4 050	3 650	14 585
Community education and development	GR	1 420	1 460	1 490	1 560	5 940
	NSF	1 565	1 630	2 945	3 320	9 460
Planning, advocacy and communication	GR	430	420	490	440	1 780
	NSF	410	360	405	430	1 605
Emergency response and rehabilitation	GR	170	170	170	150	660
	NSF	250	200	200	200	850
Programme support	GR	1 500	1 500	1 400	1 400	5 800
	NSF	350	350	400	400	1 500
TOTAL	GR	6 000	6 000	6 000	6 000	24 000
	NSF	6 000	6 000	8 000	8 000	28 000
GRAND TOTAL		12 000	12 000	14 000	14 000	52 000

GR = General resources.
NSF = New programmes for supplementary funding.

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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATIONS*

Eastern and southern Africa region

SUMMARY

The present document contains recommendations for funding programmes in the eastern and southern Africa region with annual planning levels not exceeding $1,000,000. It also contains one recommendation for additional general resources to fund the approved country programme in the same region for which the balance of approved general resources is not sufficient to fund the programme up to the approved programme period. The Executive Director recommends that the Executive Board approve:

(a) The following amounts from general resources, subject to the availability of funds, and the following amounts in supplementary funds, subject to the availability of specific-purpose contributions, for the country programmes listed below:

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Mauritius	3 750 000	500 000	1996-2000
Swaziland	3 750 000	2 750 000	1996-2000

(b) Additional general resources in the following amount to achieve the objectives of the country programme as originally approved by the Board:

Country/programme	Amount (United States dollars)	Current programme cycle
Swaziland	100 000	1991-1995

Summaries of individual recommendations follow.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

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I. MAURITIUS

Basic data (1993 unless otherwise stated)

Child population (millions, 0-15 years)	0.3
U5MR (per 1,000 live births)	22
IMR (per 1,000 live births)	19
Underweight (% moderate and severe) (1985)	23.9
Maternal mortality rate (per 100,000 live births) (1982)	99
Literacy (% male/female) (1990)	85/75
Primary school enrolment (% net, male/female) (1991)	87/90
Primary schoolchildren reaching grade 5 (%) (1991)	98
Access to safe water (%) (1990)	97
Access to health services (%) (1985)	100
GNP per capita (1992)	$2,700

One-year-olds fully immunized against:

tuberculosis:	87 per cent
diphtheria/pertussis/tetanus:	88 per cent
measles:	84 per cent
poliomyelitis:	89 per cent

Pregnant women immunized against:

tetanus:	78 per cent

The situation of children and women

1. The success of development in Mauritius in the past decade is reflected in its positive socio-economic indicators. Of all member countries of the Organization of African Unity, Mauritius has the lowest maternal mortality rate (MMR), the second lowest infant mortality rate (IMR), about the highest primary and secondary school enrolment ratios and the lowest fertility rate. Out of the 12 mid-decade goals which are relevant to Mauritius, 7 have been already achieved and the remaining 5 are on course for achievement. Those achieved include immunization coverage, elimination of neonatal tetanus, reduction in measles mortality and morbidity, elimination of poliomyelitis, ratification of the Convention on the Rights of the Child, strengthening of basic education and universal access to safe drinking water and sanitary means of excreta disposal.

2. However, in order to achieve and sustain all the decade goals, as adopted in the Mauritius national programme of action, Mauritius must meet a number of challenges in the context of its rapid economic and societal development: increased efficiency in the delivery of basic services; disparity reduction between districts; and the adoption of healthier lifestyles.

3. The priorities for children's health include reducing the high level of perinatal mortality, currently at 25 deaths per 1,000 live births, and the persistence of water-borne diseases, worm infestation and anaemia. The

declining caring capacity of families because both parents are working, changes in consumption patterns and poor nutritional and hygienic practices contribute to persistent undernutrition among children. Breast-feeding is compromised by premature weaning practices. Although no cases of vitamin A or iodine deficiencies have been reported in recent years, subclinical disorders cannot yet be ruled out. The combination of poor nutrition status of women and their heavy workloads are a hazard, especially during pregnancies, because of the high prevalences of anaemia, hypertension and diabetes, premature deliveries and low-birth-weight babies. Poor knowledge about human sexuality, contraception and low condom use are concerns in view of the rising number of people infected with the human immunodeficiency virus (HIV) - from 19 in 1992 to 80 in 1994 - and the increase in teenage pregnancies. Public health services are free, but suffer from several problems - poor management, uncertain sustainability, underutilization of rural basic health services - and the quality of care appears to be below the expectations of most users.

4. Some 30,000 children under three years of age are cared for during working hours by someone other than the mother. Caregivers are generally untrained and poorly motivated. Enrolment is 80 per cent in pre-primary schools, which are mostly private, but they have inadequate infrastructure, insufficient supervision, poor pedagogical materials and inadequately trained staff. Primary education is free and compulsory, and infrastructure, personnel and basic equipment provide universal access. However, the failure rate for the certificate in primary education is 43 per cent, with wide disparities among schools. Failures stem from low household incomes combined with low parental educational levels and marginal competency in the language of instruction. Semi-literacy and illiteracy are persistent problems. Literacy development activities cater for only 10 per cent of the need.

5. Child abuse and neglect are on the rise, and domestic violence has become a leading issue affecting family life. Although most discriminatory laws have been removed, attitudes and practices still prevent the full development and contribution of women to society. After laying the foundation of the country's economic miracle by a major reduction in births and by joining the workforce in massive numbers, women must now be able to gain access to quality day-care services which will allow them and their families to develop fully.

Programme cooperation, 1990-1995

6. The current programme, approved at the 1990 session of the Executive Board (E/ICEF/1990/P/L.17) for $1,500,000 from general resources, addressed the social problems affecting women and children, especially the need to reduce disparities between the islands of Mauritius and Rodrigues. To increase support for national efforts towards the achievement of the decade goals, the 1992 Executive Board approved an additional amount of $1,500,000 from general resources (E/ICEF/1992/P/L.35). A short-duration programme for 1995 was approved by the Executive Board in 1994 (E/ICEF/1994/P/L.19).

7. Most of the country programme objectives were met, including 95 per cent coverage of expanded programme on immunization (EPI) antigens and a reduction in IMR and in the under-five mortality rate (U5MR) from 20 and 25 to 19 and 22 per 1,000 live births, respectively. UNICEF advocacy at the highest levels of

government helped to make maximum use of the limited UNICEF resources and contributed to the rapid ratification of the Convention on the Rights of the Child in 1990 and the adoption of the national programme of action in 1992, whose decade goals are also included in the latest national development plan. As national capacity for service delivery is strong, UNICEF contributed mainly to pilot or innovative approaches, often in collaboration with non-governmental or private sector partners, in training, technical support for advocacy and policy development.

8. UNICEF support to the master plan for education helped (a) to establish nine regional centres, with an annual training capacity of 360 pre-primary teachers; (b) to launch a pilot campaign to combat school absenteeism and raise primary school completion rates; (c) to formulate the national plan of action on special education, which called for the creation of a technical unit and the preparation of a training design on the early identification of disabilities; and (d) to evaluate the national literacy programme in 1993 and reorient it towards basic education for adolescents.

9. In Rodrigues, UNICEF supported formal and informal education through teacher training and the provision of teaching aids and basic equipment. Enrolment at pre-primary schools increased from 46 per cent in 1990 to 70 per cent in 1993. With the active participation of communities, the supply of safe water and improvement of sanitation facilities were significant, and UNICEF support to this sector will no longer be required. The evaluation of the Rodrigues area-based programme highlighted the contribution of the community health workers scheme to the reduction of IMR from 34.7 to 21.1 per 1,000 live births between 1990 and 1993.

10. UNICEF assisted the national EPI through the provision of vaccines and equipment. As part of a health sector review, UNICEF sponsored studies on costing and financing of peripheral health services, roles and performances of village health committees and perinatal mortality. The national nutrition survey, supported by UNICEF, will provide the basis for a surveillance system. UNICEF assistance to the national programme for the control of the acquired immunodeficiency syndrome (AIDS) covered information, education and communication activities for groups most at risk. UNICEF and the World Health Organization (WHO) jointly supported the Baby-Friendly Hospital Initiative in the five national hospitals.

11. To strengthen further national capacity in social analysis and planning, studies were undertaken in collaboration with the United Nations Development Programme (UNDP) and universities, covering issues affecting women and vulnerable groups and those related to family problems in Rodrigues. Information, education and communication materials on healthy lifestyles, including Facts for Life, were produced and disseminated in collaboration with the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and WHO. However, pre-testing, evaluation and feedback on communication campaigns have usually been weak.

Lessons learned

12. Past cooperation indicated that the compatibility of policy goals between the Government and UNICEF, combined with the limited resource capacity of UNICEF, creates a favourable context for UNICEF roles in advocacy and policy development. Hence, country programme priorities are evolving away from service delivery issues towards the search for more rational planning of human and financial resources for the social sectors. As the development process in Mauritius is progressing rapidly, UNICEF cooperation will become more adaptive so as to respond better to emerging priorities for children and women. In this context, improved monitoring and evaluation mechanisms are of paramount importance.

Recommended programme cooperation, 1996-2000

Estimated annual expenditure

(In thousands of United States dollars)

	1996	1997	1998	1999	2000	Total
General resources						
Health	200	200	200	200	200	1 000
Education	300	300	300	300	300	1 500
Social policy development, advocacy and monitoring	250	250	250	250	250	1 250
Subtotal	750	750	750	750	750	3 750
Supplementary funding						
Health	50	50	50	50	50	250
Education	50	50	50	50	50	250
Subtotal	100	100	100	100	100	500
Total	850	850	850	850	850	4 250

Country programme preparation process

13. The latest national development plan presents the Government's policy of pursuing growth with equity and monitoring the impacts of industrialization and rapid social change in terms of changing lifestyles, particularly where family welfare is concerned.

14. The programme of cooperation was prepared by an interministerial committee and included consultations with national institutions and organizations. Existing research and surveys provided inputs for the situation analysis and programme preparation. A strategy meeting, held in May 1994, decided on major directions. Given the achievements in Mauritius in terms of child survival and

development (CSD), the proposed country programme will initiate a transitional phase leading to a gradual diminution of programme inputs after the year 2000.

Programme objectives and strategies

15. The 1996-2000 programme of cooperation will facilitate and play a catalytic role in the achievement of the goals of the Mauritius national programme of action. UNICEF cooperation will help the Government (a) to improve further the quality and utilization of basic services for women and children, with a particular focus on education and health; (b) to reduce further disparities both within and between islands; and (c) to strengthen the sustainability of progress towards the achievements of the decade goals. The programme of cooperation will focus on four of the seven strategic decade goals: (a) reduction of IMR and U5MR to 12 and 19 per 1,000 live births, respectively; (b) reduction by half of MMR; (c) reduction of severe and moderate child malnutrition to 7 per cent; and (d) acquisition of a basic education by 80 per cent of primary-school-age children. These goals were selected as they represent the centre-pieces of the country's commitment to its children.

16. As in the past, but more so in the proposed programme, UNICEF support will be used as a pre-investment strategy prior to the expansion of government programmes. The three proposed sectoral programmes - social policy development, advocacy and monitoring; health; and education - are interrelated so that results from operational research and studies will feed into activities to increase the coverage and quality of all programmes. In turn, successes will be used to generate nationwide changes in coverage through information-sharing, policy development and major advocacy activities. Based on the high education level of the public and the wide range of community organizations, IEC activities will help to increase the caring capacity of families, strengthen the demand for quality services and promote healthier lifestyles. Where capacity-building and empowerment can be critically complemented with service delivery, UNICEF will provide assistance for services on a limited basis. Programme activities will be targeted using local indicators to reach better vulnerable groups, especially women and girls, and to reduce disparities.

Social policy development, advocacy and monitoring

17. The objectives of this programme are (a) to improve the information base of all decision makers, both inside and outside Government, with responsibilities for social policy development; (b) to study ways to improve cost-effective and sustainable strategies in the current transition to the next stage of development; and (c) to foster public awareness, discussion and support for children's and women's needs and rights.

18. The strategy will be to increase capacity-building for the collection, analysis, dissemination and use of data in the policy formulation process and in monitoring progress towards the national programme of action goals. Efforts will continue to generate more disaggregated statistics to assist in identifying vulnerable groups, pockets of poverty, gender disparities and problem areas. Special attention will be paid to the financing and management of social services and other issues of relevance as a follow-up to the World Summit for Social Development and the Fourth World Conference on Women. UNICEF will

support strengthening of inter-agency collaboration in support of national efforts to develop social policies and sectoral plans, for example in health sector reform.

19. Advocacy will build on the already positive experiences in forging partnerships for children, consolidating relations with the media and producing and disseminating information on child development issues. Full use of various special events and other opportunities such as the fiftieth anniversary of UNICEF will be a priority. Based on sound and gender-sensitive research, priority for advocacy will be full implementation and dissemination of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Recurrent themes for advocacy will include the situation of women in the labour force; child abuse and neglect; women's roles in social, economic and political decision-making; parenting practices; and absenteeism of girls from school. UNICEF will continue to cooperate with the university, and a knowledge centre on children will be established. Education for development will be promoted, with an emphasis on helping children to understand and appreciate cultural and linguistic diversity in a multi-cultural and multilingual society and in the world.

Health

20. The challenge in the health sector is to achieve the decade goals, in a sustainable way, through a more rational use of financial, infrastructure and human resources. The main strategy of the health programme is to increase the efficiency of maternal and child health (MCH) services through improved utilization of more accountable and effective basic services and to reduce the prevalence of preventable communicable/non-communicable diseases.

21. The MCH project will strengthen the capacity of health services in districts with indicators reflecting less progress than national averages with respect to care for high-risk pregnancies, foetal distress and neonatal intensive care. The nutrition component will support training and information, education and communication activities (a) to promote better dietary, hygienic and child-feeding practices, including breast-feeding; (b) to promote further growth monitoring and promotion; and (c) to improve the treatment of worm infestation and diarrhoea among children. The third component of the project is aimed at improving the management capacity of mid-level and peripheral health teams. Research and analysis will be devoted to the issues of quality assurance and institutional accountability of first-line services. Local health committees and non-governmental organizations will help to set up forums to improve communication between health providers and users. While the provision of vaccines will be ensured through the government budget, UNICEF will continue to support EPI through monitoring activities.

22. The behavioural health project focuses on (a) improving reproductive health, including sexually transmitted diseases/AIDS and early pregnancies; (b) inadequate dietary and lifestyles habits; and (c) underutilization and by-passing of peripheral health facilities. UNICEF will assist with the development of appropriate health promotion materials and provide technical support to the information, education and communication unit of the Ministry of Health. Based on research and analysis, UNICEF cooperation to improve

utilization of MCH services will develop communication strategies to encourage parents to use nearby MCH services.

Education

23. The focus of the education programme is (a) to develop standards for early childhood development; (b) to expand early childhood development activities to cover 70 per cent of children under the age of three years; (c) to achieve universal access and improvement of the quality of pre-primary education; (d) to reduce failure rates in low achieving primary schools from 70 to 40 per cent; and (e) to reduce illiteracy in adolescents from 7.5 to 3.7 per cent for the island of Mauritius and from 29.3 to 14 per cent for the island of Rodrigues. The programme will target low performing primary schools and day-care centres whose children move on to those schools.

24. The early childhood development project targets 101,500 children under five years of age and their families. Priority will be for policy development, establishing regulations and training of supervisors, managers and day-care givers. An information, education and communication campaign will raise parental awareness of child development issues, promote child care and stimulation, and create a demand for quality services. In early childhood development, UNICEF will support in-service teacher training and the development of pedagogical materials, including emphasis on achievement of linguistic skills.

25. The basic education project will support a comprehensive approach to increase certificate of primary education success rates in low performing schools. UNICEF assistance will cover activities such as supplementary education, improving the learning environment, research and analysis and literacy activities for 13,000 adolescents. UNICEF will support curriculum review, essential learning and teaching materials and training for literacy activities.

Cooperation with other agencies

26. The country programme was developed in consultation with other United Nations agencies in Mauritius in line with a country strategy note (1994-1997) being prepared by the Government. Ongoing collaboration will be further developed with WHO and the United Nations Population Fund (UNFPA) for technical support in youth reproductive health, MCH and nutrition activities; with UNDP for support to operational research in social sector financing; and with the World Bank in early childhood development activities and health sector reform. Follow-up will be undertaken on the joint United Nations Educational, Scientific and Cultural Organization (UNESCO)/UNICEF project on the monitoring of Education for All.

Programme management

27. Overall coordination will be the responsibility of the Ministry of Economic Planning and Development, which will collaborate with UNICEF on all aspects of the programme, especially intersectoral coordination among participating ministries, non-governmental organizations and other partners. Implementing

ministries and agencies will designate officers as focal points to UNICEF for this cooperation. A monitoring and evaluation plan has been prepared as part of the country programme. Relevant ministries will provide data for indicators as part of their regular information-gathering activities for quarterly progress reports. Annual reviews of programme implementation will be organized to provide the basis for the preparation of annual project plans of action. A mid-term review is planned for 1998 to assess the effectiveness of strategies and progress towards the objectives so that course corrections can be made as appropriate.

28. Past experience, including with Greeting Card and related Operations, indicates that a number of local non-governmental organizations, service clubs and enterprises are willing to undertake fund-raising activities for UNICEF.

29. The UNICEF sub-office in Mauritius is headed by one international Professional staff and supported by three national Professional officers (for programme, information/communication and operations work). Given the high level of technical support required by the proposed programme of cooperation, additional support will be sought through the United Nations Volunteers programme.

II. SWAZILAND

Basic data (1993 unless otherwise stated)

Child population (millions, 0-15 years)	0.4
U5MR (per 1,000 live births)	141
IMR (per 1,000 live births) (1992)	98
Underweight (% moderate and severe) (1983-1984)	9.7
Maternal mortality rate (per 100,000 live births) (1990)	110
Literacy (% male/female) (1986)	70/65
Primary school enrolment (% net, male/female) (1994)	80/78
Primary schoolchildren reaching grade 5 (%) (1990)	80
Access to safe water (%) (1990)	60
Access to health services (%)	85
GNP per capita (1992)	$1,090

One-year-olds fully immunized against:

tuberculosis:	98 per cent
diphtheria/pertussis/tetanus:	89 per cent
measles:	85 per cent
poliomyelitis:	86 per cent

Pregnant women immunized against:

tetanus:	74 per cent

The situation of children and women

30. Swaziland is a patrilinear society in which many of the traditional structures are inextricably interwoven with modern ones and, therefore, influence social norms, politics, law and the economy. All Swazis are formally subjects of one of the 200 chiefs through whom land is allocated. Chieftainships are grouped under 55 administrative centres called Tinkhundla, which, in turn, are grouped into four regions, each with a regional administrator and a regional health management team.

31. The estimated population for 1994 is 894,100 and the per capita gross national product is $1,050. However, poverty and deprivation have increased in the 1990s owing to declining family incomes. In this connection, 39 per cent of all households are headed by women, with an incidence of poverty nearly double that of male-headed households. Some 72 per cent of Swazis are rural dwellers, many of whom live in absolute poverty. Poverty could worsen owing to an anticipated reduction in the Southern African Customs Union transfers to Swaziland, which account for nearly one half of government budget resources.

32. In the mid-1980s, Swaziland experienced rapid economic growth and progress towards achieving the goals for children for the year 2000. Immunization coverage of infants rose from 14 to 89 per cent and use of oral rehydration therapy (ORT) is estimated at 84 per cent. Life expectancy has increased by 29 per cent and IMR declined by an impressive 41 per cent from 168 per 1,000 live births in 1966 to 98 in 1992. However, infant and under-five mortality are highest in the savannah eastern part of Swaziland.

33. One quarter of all infant mortality occurs during the neonatal period owing to low birth weight, congenital syphilis or perinatal conditions. Some 55 per cent of all infant deaths occur between the second and sixth months of life. Hence, in contrast to many other countries, the majority of infant deaths occur after the neonatal period. Most infant deaths could be prevented through relatively simple initiatives by villages and Tinkhundla by giving greater attention to improved antenatal and post-natal care. Acute respiratory infections (ARI), diarrhoeal diseases and malnutrition, combined with non-exclusive breast-feeding, poor weaning practices and unsanitary living conditions, account for 53 per cent of reported infant mortality and 70 per cent of under-five deaths.

34. A national AIDS programme sentinel surveillance survey estimates HIV prevalence at 18.5 per cent among the sexually active population as opposed to 3.9 per cent in 1992; 18 and 58 per cent of reported AIDS cases are in children under 4 years of age and adults between 20 and 39 years of age, respectively. Some 23 per cent of mothers aged 15-19 years are HIV-positive, and females in this age-group are infected at a rate four times greater than that of males. It is estimated that by 1996, 5 per cent of all Swazi children will be orphaned because of AIDS.

35. The official MMR of 110 per 100,000 live births is probably underestimated as the sample covers only 56 per cent of deliveries, those which occur in health facilities. Some 75 per cent of maternal deaths are a result of direct obstetric causes of induced abortion, eclampsia, obstructed labour, haemorrhage

and infection. The remaining maternal deaths are attributed to the mother's age, high parity, closely spaced pregnancies, multiple infections and poor nutritional status. Teenage pregnancies account for 27 per cent of all recorded deliveries, a figure that could rise as the high population growth rate of 3.2 per cent creates a larger adolescent population.

36. Chronic malnutrition affects 3 out of every 10 children. Undernutrition is a serious problem between the ages of 6 and 24 months and is associated with inadequate breast-feeding and weaning practices. Virtually all mothers initiate breast-feeding and continue nursing up to 18 months, but only 8 per cent practise exclusive breast-feeding. Two thirds of all infants are introduced to supplementary foods at age two months, and breast-feeding is often interrupted when the baby is ill.

37. A 1993 iodine deficiency survey confirmed that moderate to severe iodine deficiency ranges from 6 to 38 per cent, with the most acute situation in western Swaziland. Although a study of vitamin A deficiency has yet to be undertaken, the relatively high infant and child morbidity and mortality rates suggest a problem, especially in areas with chronic drought.

38. Although the Government currently spends 41 per cent of its revenue on social programmes, the population living in isolated, rural pockets is still underserved. For example, only 16 per cent of the three- to five-year age-group are enrolled in pre-schools. The annual primary school drop-out rate is 5 per cent and the repetition rate is 26 per cent. There is social pressure on girls to leave school upon completion of primary education to work or if they become pregnant. In 1994, gross and net enrolment rates for primary school were 100 and 80 per cent, respectively, and the adult literacy rate was 70 per cent.

39. Some 80 per cent of the urban population and 40 per cent of rural dwellers have access to safe drinking water. This level may not be sustained unless there is a more clearly defined government policy on sustainability and improved maintenance of water systems.

40. The most important challenge to improving and maintaining the health and educational status of women is to elevate their position in Swazi society to one of equal standing with men. Although women are legally ensured of equality of opportunity for employment, they have limited access to managerial positions. Also, women's rights are not sufficiently protected regarding property ownership and inheritance. Furthermore, marriage laws classify women as minors who need the consent of their husbands regarding legal matters. Field observation suggests that a significant number of girls are street children or adolescent prostitutes.

Programme cooperation, 1991-1995

41. The 1991-1995 programme of cooperation focused mainly on increasing coverage of basic services by providing supplies, e.g., essential drugs and equipment, to strengthen service delivery systems, in particular MCH care services.

42. UNICEF supported MCH mainly through (a) training of health personnel and community volunteers on preventive, promotive and curative health; (b) social mobilization and advocacy; and (c) procurement of supplies. In 1991, UNICEF procured almost all of the country's supply of vaccines. However, in 1993 the Government began to procure 50 per cent of the national vaccine requirements. UNICEF support for communication and social mobilization helped to increase and sustain the commitment of political leaders and the demand for immunization services among mothers. The mid-decade targets of eliminating poliomyelitis and neonatal tetanus, therefore, appear achievable. As the immunization programme is integrated with other MCH activities, reaching the target for universal child immunization has also strengthened the entire system for health services.

43. With regard to the Baby-Friendly Hospital Initiative and the household food and income security programme, the Government developed a policy on infant feeding for all health centres based on the "ten steps to successful breast-feeding". There are six major hospitals in Swaziland, of which four were assessed as "baby-friendly" and another two received certificates of commitment. The country programme framework was adjusted, and UNICEF also supported hand-pump installation and pit latrine construction as part of a drought emergency intervention.

44. The basic education programme was discontinued because it was comprised of a disparate set of interventions with insufficient integration. However, as a result of the mid-term review, its elements were incorporated into a newly created social mobilization programme.

Lessons learned

45. The 1993 mid-term review of the country programme was seminal in that a new strategic approach emerged for both implementation of sectoral programmes and the UNICEF programme management role.

46. The assessment concluded that the country programme had too many projects (17) and that the activities were not sufficiently integrated within a comprehensive strategic framework. With the advent of the national programme of action in 1991, it became clear that Government-UNICEF cooperation should strengthen monitoring of progress towards achieving and sustaining the national programme of action goals as there was limited national capacity for the systematic monitoring of the situation of children. Furthermore, more viable programmatic approaches were needed for underserved areas.

47. The cooperation also needed to give greater attention to programme management systems rather than focus too heavily on a supply-oriented approach for increasing access to services as Tinkhundla, and the chiefdoms were becoming more actively involved in service delivery. The Tinkhundla can help to improve coordination between the central administrative regions and communities.

48. The population is scattered in homesteads, and the mountainous terrain makes some areas difficult to access. Although coverage for services such as immunization and ORT is already high, it is not universal. Therefore, more consistent and long-term efforts should be made to extend services to difficult to serve areas, including the urban poor.

49. Research suggests that although people's knowledge about children's and women's needs is often high, their behaviour is often at odds with promotive health norms. For example, knowledge about contraception and AIDS is relatively high, but the actual use of contraceptives and condoms is only 22 per cent. Over 96 per cent of pregnant women make at least one antenatal clinic visit, but only 56 per cent deliver in health facilities.

50. UNICEF assistance for service delivery is still necessary, primarily to fill clearly identifiable gaps on a short-term basis. A more long-term role for UNICEF in Swaziland will be to advocate with the Government for more effective mobilization of other service agencies, including non-governmental organizations and the private sector. UNICEF cooperation should evolve to focus more on policy advocacy as a means to expedite programme implementation at all administrative levels. For example, cost-effective ways to promote the Convention on the Rights of the Child need to be identified, such as the Convention providing a concrete ethical basis for achieving the decade goals and addressing other issues such as HIV/AIDS prevention.

51. It is important to strengthen strategies, e.g., self-sufficiency in vaccines, which will sustain the gains made in primary health care (PHC). Such strategies would include (a) additional government resources for the recurrent costs for vaccines and oral rehydration salts (ORS); (b) the promotion of community ownership of activities and community financing; and (c) increasing the capacity of local leadership to plan and manage projects.

Recommendation for additional general resources for the approved country programme, 1991-1995

52. The country programme for Swaziland for the period 1991-1995 was approved by the Executive Board in 1991 with available general resources of $2,500,000 (E/ICEF/1991/P/L.20). In 1994, the Executive Board approved an additional $919,340 from general resources for the programme period (E/ICEF/1994/P/L.30). The Executive Board is being requested to approve an additional amount of $100,000 from general resources for 1995 to accelerate activities for achieving the remaining mid-decade goals as well as to maintain and improve on the achievements made thus far. The focus will be on maintaining high levels of immunization coverage (89 per cent), with particular emphasis on eradicating poliomyelitis, eliminating neonatal tetanus and reducing the incidence of measles. The use of ORT, currently estimated at 84 per cent, will be increased to 90 per cent by 1995. To combat the high morbidity and mortality rates, UNICEF will continue to provide essential drugs, including vaccines and ORS, support refresher training of health staff and promote health education. Another priority will be to strengthen the decentralization of health services and to build regional capacity for effective preventive, curative and health promotion services. Safe motherhood will be addressed more vigorously in order to improve the quality of prenatal and maternity care services, especially with respect to emergency interventions. Malnutrition, reflected in the high rate of stunting of children under five years old, will continue to be a major concern. UNICEF will support activities for promoting breast-feeding and improved young child-feeding practices through community-based initiatives.

Annual funding requirements

(In thousands of United States dollars)

Current programme cycle	Approved general resources funding a/	Additional funding proposed 1995	Total
1991-1995	650	100	100

a/ The amount shown here includes the actual balance carried over from the previous programme cycle.

Recommended programme cooperation, 1996-2000

Estimated annual expenditure

(In thousands of United States dollars)

	1996	1997	1998	1999	2000	Total
General resources						
Social policy development	75	80	90	90	105	440
Health and nutrition	375	320	340	290	300	1 625
Water supply and environmental sanitation	105	120	95	105	90	515
Basic education	80	115	95	115	105	510
Programme support	115	115	130	150	150	660
Subtotal	750	750	750	750	750	3 750
Supplementary funding						
Social policy development	95	90	110	95	50	440
Health and nutrition	205	230	245	245	275	1 200
Water supply and environmental sanitation	100	120	100	90	110	520
Basic education	150	110	95	120	115	590
Subtotal	550	550	550	550	550	2 750
Total	1 300	1 300	1 300	1 300	1 300	6 500

Country programme preparation process

53. The strategy meeting, which produced a programme framework, was followed by a programme formulation process, based on intensive Government-UNICEF consultations, including comments from some UNICEF Executive Board member countries. The 1996-2000 programme of cooperation builds on the likelihood of Swaziland achieving and sustaining the mid-decade goals and on the lessons learned during the previous country programme. The achievement of the mid-decade goals will be used as a springboard for achieving the major national programme of action goals for the year 2000.

54. The two country programme objectives, which will serve as a catalyst for achieving the national programme of action goals, provide a role for UNICEF cooperation that is complementary to the roles of other United Nations agencies involved in social development. In all programme sectors, UNICEF Swaziland will apply three approaches: (a) building capacity by providing financial and technical support to implementing partners for local-level planning, monitoring and programme implementation; (b) reinforcing support services by developing programme communication, advocacy and social mobilization; and (c) maintaining the provision of supplies for deprived rural and urban areas.

55. The first objective is to promote implementation of the national programme of action goals nationwide through advocacy and social mobilization. The second objective is to contribute and support the major national CSD goals, especially for children most at risk, in selected rural and urban areas. In these selected locations, UNICEF cooperation will help to achieve the following national programme of action goals, or their equivalents, based on targets developed by local government administrations: to reduce IMR from 98 to 75 per 1,000 live births; to reduce U5MR from 141 to 110 per 1,000 live births; to reduce MMR from 110 to 75 per 100,000 live births; virtually to eliminate iodine deficiency disorders (IDD) and vitamin A deficiency; to increase to 90 per cent the proportion of all primary schools, clinics and outreach sites with access to safe drinking water and sanitary means of excreta disposal; and to increase the primary school completion rate to 85 per cent within the areas of programme implementation.

Objectives and strategies

56. The main goal will be to move beyond increasing coverage of basic services to achieve a more positive impact on child survival, development and protection. The objectives of the national programme of action will be pursued in the geographical areas designated for UNICEF cooperation. The country programme strategy employs the following three main interrelated types of strategies: (a) sustaining and increasing the coverage of social services; (b) strengthening the quality of service delivery and social planning; and (c) empowering Swazi citizens, particularly women, for greater participation in the development process. The structure of UNICEF cooperation includes improving the quality and impact of direct services (e.g., safe motherhood) and more systematic support services (e.g., social policy developments for children and women). The country programme will also have two mutually supportive components: (a) sectoral cooperation, with an emphasis on delivering inputs for direct services through ministries and departments, primarily on a national basis (e.g., health, water

supply and education); and (b) cross-sectoral support services (advocacy, social mobilization, communication, planning and monitoring), with a focus on local-level capacity-building and community empowerment. The phasing of programme implementation will include an additional 11 Tinkhundla per year for a total of 55 Tinkhundla, or about 20 per cent of the population. However, UNICEF will assist virtual universal immunization coverage of infants and universal consumption of iodized salt. Advocacy and social mobilization activities will be nationwide. There are four strategies themes which permeate the country programme.

57. Responsiveness to community initiatives. Development of more effective local-level participatory mechanisms will promote more productive collaboration between governmental and customary governance (e.g., chieftainships). In addition, there will be an ongoing dialogue between the providers of basic services and organized groups of beneficiaries from communities.

58. Sustaining survival achievements. Strengthening the sustainability of service delivery for successful national programmes, such as EPI, will focus on five interrelated factors: long-term political support; financial resources; managerial competence; technical expertise; and cultural acceptance.

59. Disparity reduction. The relatively high levels of child malnutrition and under-five mortality indicate that many children have not benefited from the economic boom of the 1980s. Therefore, disparity reduction will be an overarching concern in itself and essential to achieving the national programme of action goals. UNICEF cooperation will target children at high risk in both rural and urban areas.

60. Information, advocacy and social mobilization for policy development. Government-UNICEF cooperation will engage in high-level and national-level advocacy with policy makers, legislators and other donors for improving the social and legal environment for children and women. Social mobilization in all regions and communities, combined with the provision of technical assistance for programme planning and management and better utilization of national resources, will strengthen implementation of national policies as they are adapted to local conditions. Through more targeted communication and training, the country programme will improve the impact of information dissemination and strengthen the motivation and abilities of communities and families to provide leadership for and support initiatives.

Social policy development

61. This programme aims at strengthening government-wide programme planning and advocacy for children and women so that children's needs and gender equity become higher priorities on Swaziland's development agenda. The programme will establish a policy and legislative framework based on the Convention on the Rights of the Child for safeguarding the basic rights of children and women. Strategies for decentralization and community participation should empower communities to promote government accountability for children and women's rights.

62. Programme communication activities will be included in all programmes. Activities will help to build government and NGO capacities to undertake communication initiatives considered essential for achieving the country programme objectives. There will be an emphasis on standardizing messages and coordinating information dissemination through all governmental, NGO and donor parties involved in the programmes. Advocacy and social mobilization for child protection and gender equity will address gaps in legislation and the need for behavioural changes. A special concern will be the protection and development of children and women in difficult circumstances, e.g., the impact on children whose parents die from AIDS and the right of these children for care. The planning, evaluation and goals monitoring components will strengthen these capacities at national, regional and community levels.

63. An integrated monitoring and evaluation plan has been designed to cover all sectoral programme plans of operation. A mid-programme review is planned for 1998 and an impact evaluation for the year 2000. Systematic data collection and analyses will be undertaken annually at community and regional levels by various governmental institutions and organizations, including non-governmental organizations and rural health motivators. A national programme of action monitoring and evaluation group will promote and coordinate periodic analyses of the situation of children and women and suggest improvements for supervision, monitoring and evaluation systems. Allocations to human development priorities will also be monitored, together with per capita spending on basic services. External resources for the national programme of action will be mobilized through an emphasis on private sector fund-raising. Regional action plans will be prepared annually as part of the rolling, three-year national budgeting and planning process.

Health and nutrition

64. The integrated health and nutrition programme aims to increase quality, access and coverage of basic health services for at least 150,000 underserved rural and urban children and women. The strategy is to reinforce the present integration of maternal health, EPI, the control of diarrhoeal diseases (CDD), ARI and nutrition activities into a comprehensive PHC service package, whose management will be strengthened at regional and community levels. Activities will focus on building the capacity of regional health management teams and strengthening the working relationships between them. Clinic nurses and community extension workers will be critical to the integration process. Regional health management teams will improve communication services with families. Special attention will be given to the development of interpersonal skills of health and family planning workers who work directly with families. UNICEF support to the health sector will be closely coordinated with assistance from several other donors such as WHO, the United States Agency for International Development (USAID), UNFPA and various non-governmental organizations.

65. EPI will add additional activities as a "plus component" and will (a) distribute vitamin A capsules to both children under five years of age and lactating mothers; (b) increase and sustain present immunization coverage levels; (c) expand the focus from mainly immunization coverage to disease reduction; (d) strengthen disease surveillance capacity; and (e) further develop

a sustainable vaccine supply and financing system by focusing on local government support. These will be achieved by identifying the underserved areas, maintaining advocacy at all administrative levels and strengthening management and supervision responsibilities at regional levels. Health staff in all 55 Tinkhundla will be trained in improved disease surveillance for the eradication of poliomyelitis and neonatal tetanus and the further reduction of measles morbidity and mortality.

66. The major strategy for safe motherhood and family planning will be to promote and improve access to prompt and competent emergency obstetric services. The quality of emergency care for obstetric complications will be improved through ensuring the availability of basic equipment and decentralizing the management system. Other related interventions will include the training of 500 traditional birth attendants, creating awareness and promoting action with communities for improved maternal care, and supporting the establishment and upgrading of other maternal health services at district and regional levels. The problem of adolescent reproductive health will be addressed through expanding family life education so as to reduce the risks of unwanted pregnancies and sexually transmitted diseases, including HIV infections in girls aged 15-19 years.

67. HIV/AIDS education for youth is aimed primarily at achieving a change in the sexual behaviour of Swazi adolescents in all 500 primary schools. Culturally compatible and novel teaching and learning materials, including gender-sensitizing topics and life skill modules, will be developed to promote sexually responsible attitudes and behaviours. Furthermore, children will be supported as "knowledge carriers" so that they are able to transmit what they have learned in school into their homes and communities. The mobilization and support of head teachers, teachers, parents, members of school committees and traditional leaders will also be a priority.

68. CDD and ARI services will focus on the prevention of diarrhoeal diseases and on correct standard case management of watery, bloody and persistent diarrhoea and ARI. This will be done through the training of 1,000 health staff and social mobilization and communication activities. Hard-to-reach areas, including peri-urban zones, will be identified and targeted where households may not have sufficient access to information about ORT or sufficient quantities of ORS sachets. Home therapy for the treatment of diarrhoeal episodes, coupled with emphasis on continued feeding and early recognition and appropriate referral of ARI cases to health facilities, will be promoted.

69. The promotion of breast-feeding and appropriate weaning practices is aimed at improving the proportion of exclusively breast-fed babies from 8 to 50 per cent and promoting appropriate weaning practices for children under three years of age. This will be achieved by promoting breast-feeding through non-formal education, communication and social mobilization channels. The target groups will be girls and women 15-25 years of age who account for more than 50 per cent of all deliveries. Support will be continued to the Swaziland Infant Nutrition Action Network to strengthen the Baby-Friendly Hospital Initiative in six hospitals and to expand it to other health facilities (public and private) with maternity services.

70. An initiative on the elimination of micronutrient deficiencies is aimed at improving the nutritional status of children under five years of age and women of child-bearing age. As all salt for human consumption comes from South Africa, IDD will be eliminated by enforcing legislation on the importation of iodated salt and advocacy with the public on the importance of the consumption of iodated salt. Constant monitoring of IDD indicators in high-risk areas will be carried out systematically by health workers. Vitamin A and iron deficiencies will be addressed by (a) encouraging the home production and consumption of vitamin A- and iron-rich foods; (b) providing iron and vitamin A capsules to high-risk children and women; and (c) sensitizing the public and mothers, in particular, on the importance of providing a healthy diet for young children.

Water supply and environmental sanitation

71. The programme comprises two components: (a) the provision of safe water and Blair ventilated improved pit latrines to primary schools and clinics; and (b) the promotion of environmental health education. The overall objective of the programme is to increase the proportion of the rural population with access to safe water and adequate sanitation, to reduce the incidence of diarrhoeal diseases for about 50,000 schoolchildren and to treat in-patients and out-patients in 50 clinics and outreach health stations. A principal focus is on improving family awareness of environmental health issues. The regional health management teams will be the principal agents to reinforce health education in primary schools and clinics. An intersectoral approach will be developed to involve primary schools, women's organizations, mass media and community leaders in reinforcing hygiene education.

72. UNICEF will advocate for a country-wide water supply and sanitation programme based on affordable, appropriate technology for hand-pumps and Blair latrines. This option would keep the per capita cost within the accepted global norm of $10-$20. Community training and participation in the management, operation and maintenance of a safe water supply is an integral part of the programme. As Swaziland has a high per capita cost for rural water supply, UNICEF advocacy for the hand-pump option would help to accelerate rural water supply coverage.

Basic education

73. The emphasis of basic education will be on improving the overall quality of primary education by doubling the number of children who graduate through reducing drop-out and repetition rates by 50 per cent. UNICEF assistance will cover 150 out of a total of over 500 primary schools. These schools will be selected according to criteria including equitable geographic representation, achievement scores, repetition and net enrolment rates and the strength of the school committees. To maintain high enrolment rates and to address gender issues, priority will be given to sensitizing communities on the development needs of children and the importance of primary education. Implementation will be mainly at the subnational level, with a strong emphasis on involving communities in managing educational activities.

74. At the national level, UNICEF will assist in improving the primary school curriculum through continuous assessments and incorporation of health education. Primary school teachers will be trained in monitoring and assessment techniques. Hard-to-reach youth will be attracted and retained by developing alternative and more creative strategies for both formal and non-formal education. Efforts will also be made to increase access and make the educational system more flexible and efficient. Moreover, a policy advocacy component will address various costs and financing issues related to improving the quality and relevance of primary education and giving more attention to impoverished children and especially the girl child.

Cooperation with other organizations

75. UNICEF will work closely with other United Nations agencies, donors and national non-governmental organizations to further develop cooperation in operational research, supervision, monitoring, training and enhanced information exchange. A technical working group is planning and overseeing implementation of a decentralized, "Health for All" package. UNICEF, WHO and UNFPA have been cooperating effectively on this initiative since 1993 to promote the active involvement of regional structures and communities in MCH programmes. Other coordination activities are planned to sustain MCH achievements and, at the same time, strengthen interventions pertaining to EPI, AIDS prevention, the safe motherhood initiative, improved nutritional practices and environmental care. Many donors, including UNICEF, are working with the Government to formulate a national development strategy. With respect to the country strategy note, UNICEF will strengthen its cooperation with United Nations agencies, the World Bank and the Overseas Development Administration (United Kingdom) on poverty alleviation, with a focus on reducing disparities in coverage of basic social services. During the first two years of the country programme, UNICEF will cooperate with USAID in the education sector to strengthen capacity for assessment and information management systems in primary schools.

Programme support and management

76. To respond to the new programmatic needs and to meet the requirements of the new strategies of decentralization, the management and staffing structure of the UNICEF office will need a realignment of responsibilities, including for management and monitoring of decentralization and social mobilization activities. Staff will assume additional tasks, including more frequent field visits to monitor implementation.

77. A genuine devolution of central government management responsibilities to regional and Tinkhundla levels is essential for the successful implementation of the country programme. At the national level, the Ministry of Economic Planning and Development, jointly with the Central Office for Tinkhundla, will be responsible for the overall coordination of the programme of cooperation. They will ensure that adequate support is given to regional and Tinkhundla level structures in terms of supplies, manpower, finances and coordination.

78. The responsibilities of the regional governments for the implementation of various programmes will be specified in annual regional project plans of action. Within this management framework, one of the unique funding approaches to be

developed will be the identification and use of community and regional resources, which could increase the organizational and operational efficiency of the Tinkhundla. Continued support from donors and the private sector will be essential.

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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Syrian Arab Republic

SUMMARY

The present document contains recommendations for funding programmes in the Middle East and North Africa region with an annual planning level not exceeding $1,000,000. The Executive Director recommends that the Executive Board approve the following amount from general resources, subject to the availability of funds, and the following amount in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme listed below.

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Syrian Arab Republic	5 000 000	5 000 000	1996-2000

A summary of the recommendation follows.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

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SYRIAN ARAB REPUBLIC

Basic data (1993 unless otherwise stated)

Child population (million, 0-15 yrs)	6.9
U5MR (per 1,000 live births)	39
IMR (per 1,000 live births)	33
Underweight (% moderate and severe)	..
Maternal mortality rate (per 100,000 live births) (1990)	140
Literacy (% male/female) (1990)	78/51
Primary school enrolment (% net, male/female) (1991)	100/94
Primary school children reaching grade 5 (%) (1992)	92
Access to safe water (%) (1991)	74
Access to health services (%)	90
GNP per capita (1992)	$1,160

One-year-olds fully immunized against:

tuberculosis:	91 per cent
diphtheria/pertussis/tetanus:	90 per cent
measles:	86 per cent
poliomyelitis:	90 per cent

Pregnant women immunized against:

tetanus:	86 per cent

The situation of children and women

1. Although family planning services are widely available, the contraceptive prevalence rate is only 40 per cent. The annual population growth rate from 1965 to 1992 was 4.3 per cent, and the total population increased from 12.5 million to 13.3 million during 1990-1992. High rural-urban migration has led to the growth of squatter settlements and has strained the social service delivery system, especially in Damascus and Aleppo.

2. In 1993, the economy grew by 11 per cent because of the oil and agricultural sectors. However, inflation increased by 20 per cent. The Syrian Arab Republic's increasing engagement with the international community, along with continued economic expansion, could create new opportunities for improving the conditions of children and women.

3. The Government signed the Declaration of the World Summit for Children in 1990, ratified the Convention on the Rights of the Child and prepared a national programme of action (NPA) for children in 1993.

4. The infant mortality rate (IMR) declined from 97 per 1,000 live births in 1970 to 33 per 1,000 live births in 1993, and the under-five mortality rate (U5MR) decreased from 201 per 1,000 live births in 1960 to 39 per 1,000 live births in 1993. The maternal mortality rate (MMR) was halved from 280 per 100,000 live births in 1978 to 140 per 100,000 live births in 1990.

5. Fifty-two per cent of infant deaths occur in the first month of birth. Major causes of infant mortality include congenital problems, 49 per cent; intestinal infections and diarrhoeal diseases, 20 per cent; acute respiratory infections (ARI), 10 per cent; the six vaccine-preventable diseases,

3.5 per cent; accidents, 3.5 per cent; and others, 14 per cent. IMR is 32 per 1,000 live births in urban areas and 37 per 1,000 live births in rural areas; it is 38 per 1,000 live births for boys and 32 per 1,000 live births for girls. Major cause of U5MR are diarrhoeal diseases, 25 per cent; accidents, 16 per cent; congenital anomalies and physical deformities, 13 per cent; ARI, 10 per cent; vaccine-preventable diseases, 7 per cent; and others, 28 per cent.

6. Over 90 per cent of maternal deaths could be prevented by improving prenatal care and referral systems. A UNICEF-sponsored survey in 1994 showed that approximately 40 per cent of pregnant women were anaemic. Only 33 per cent of pregnant women visited a health centre/clinic for prenatal care; of these, only 15 per cent attended on a regular basis. Thirty-three per cent received no medical assistance throughout their pregnancy. Some 63 per cent of all births take place at home, and 83 per cent of these are assisted by trained health staff. Approximately 42 per cent of deliveries in urban areas are attended by physicians and 9 per cent by dayas (traditional birth attendants); in rural areas, 29 per cent of births are attended by dayas and 28 per cent by midwives.

7. While 81 per cent of mothers breast-feed for up to four months, only 50 per cent do so for 9 to 12 months. The 1993 Pan-Arab Project for Childhood Development survey revealed that 2.8 per cent of boys and 3.2 per cent of girls were under weight; 2.6 per cent of boys and 1.5 per cent of girls were wasted; and 13 per cent of boys and 11 per cent of girls were stunted.

8. While 50 per cent of the population live in rural areas, most pre-school services are in urban areas. Only 6.4 per cent of 3- 6-year-olds attend kindergartens. Of these, 55 per cent are male and 45 per cent female. Low enrolment and gender disparity underscore the need for additional home and community-based early childhood care.

9. Compulsory primary education was introduced in 1981. By 1993, the net primary school enrolment rate was 100 per cent for boys and 94 per cent for girls. The drop-out rate is 3.2 per cent - with no gender disparity. The repetition rate is 8 per cent - 9 per cent for males and 7 per cent for females. Classroom teaching promotes mainly learning by rote; students are trained to pass examinations. School curricula should impart more knowledge and skills required for daily life. Teaching methods should do more to help develop children's analytical skills.

10. The law provides equal rights for women, and women participate in political life. Although the IMR and the nutrition status of girls are better than the IMR and nutrition status of boys, primary school enrolment of girls lags behind. More telling, however, is the adult literacy rate which is 51 per cent for females and 78 per cent for males.

11. Household access to television and radio is 84 per cent. Thus, the reach of electronic media is becoming nationwide and could help to accelerate achievement of the decade goals for children.

Programme cooperation, 1991-1995

12. The 1991-1995 programme of cooperation included four major programmes: health; nutrition; basic education; and advocacy and social mobilization. The objective was to build a strong base for achieving global and national mid-decade and end-decade goals. Universal child immunization was achieved and sustained; and the Syrian Arab Republic is self-sufficient in vaccines. Expanded programme on immunization (EPI) coverage in 1993 was 91 per cent for anti-tuberculosis vaccine; 90 per cent for combined diphtheria/pertussis/tetanus and poliomyelitis vaccines; and 86 per cent for measles and tetanus immunization for pregnant women. No cases of poliomyelitis were reported in 1993 and 1994.

The distribution of free breast-milk substitutes in hospitals and other health facilities has been banned. The prospects for achieving other mid-decade goals are good.

13. UNICEF support to EPI included the provision of vaccines and cold-chain equipment, training of 132 health staff and awareness-raising campaigns. There is still need to reduce regional disparities in coverage, improve surveillance/reporting systems and integrate private and public sector activities. In the area of the control of diarrhoeal diseases (CDD), 670 health staff were trained, five public awareness-raising campaigns were conducted, 53 oral rehydration therapy (ORT) corners were established and a system for sentinel reporting was developed. Case management of diarrhoea at home and at health facilities too often includes the use of inappropriate antibiotics and anti-diarrhoeal drugs. Improvements needed include acceleration of public awareness, strengthening surveillance systems and revising medical school curricula.

14. Safe motherhood activities improved the training of medical and health staff, promoted tetanus toxoid vaccination for women, provided health education on family planning and maternal health care, and trained 604 health staff and traditional birth attendants. However, utilization of maternal and child health (MCH) services remains low and should be increased. Control of ARI activities raised public awareness, supported the training of 550 health staff and the establishment of one demonstration/training centre, and provided basic equipment to 250 primary health care (PHC) centres. Accelerating and decentralizing staff training, integrating control of ARI into the MCH system and improving the reporting system are priorities.

15. Management problems that need to be addressed include decentralization of the health care system; closer cooperation between the PHC system and medical schools and health training institutes; and strengthening communications between the community and PHC system.

16. UNICEF support to breast-feeding and the Baby-Friendly Hospital Initiative included policy development and the training of 620 health staff. Eleven of the 20 targeted hospitals have been certified as "baby-friendly"; all 20 should be certified by 1995. A next step is to develop an approach for promoting breast-feeding at home, workplaces and all health care facilities. A policy on iodine deficiency disorders (IDD) was formulated based on a 1990 UNICEF-supported IDD survey; 17 per cent of the salt is iodized and all edible salt should be iodized by 1995.

17. For early childhood development (ECD), 200 kindergarten teachers from underserved areas were trained, and supplies and equipment were provided to 500 kindergartens. For primary education, Facts for Life learning materials were developed. UNICEF assisted with upgrading the environmental conditions of 35 rural schools. Also, 300 literacy leaders were trained and 50,000 literacy materials produced. The addition of knowledge and basic life skills in primary school curricula and promoting girls' education are high priorities.

18. UNICEF support for advocacy and social mobilization covered 10 national workshops; 100 media campaigns; child and youth activities, e.g., summer camps; and 10,000 copies of materials to promote the NPA.

Recommended programme cooperation, 1996-2000

Estimated annual expenditure

(In thousands of United States dollars)

	1996	1997	1998	1999	2000	Total
General resources						
Health	230	230	230	230	230	1 150
Nutrition	60	60	60	60	60	300
Education	180	180	180	180	180	900
High-risk, area-based programme	260	260	260	260	260	1 300
Social mobilization	70	70	70	70	70	350
Programme support	200	200	200	200	200	1 000
Subtotal	1 000	1 000	1 000	1 000	1 000	5 000
Supplementary funding						
Health	100	300	200	200	200	1 000
Nutrition	100	100	100	100	100	500
Education	200	300	350	200	200	1 250
High-risk, area-based programme	200	400	300	300	300	1 500
Social mobilization	50	50	50	50	50	250
Programme support	100	100	100	100	100	500
Subtotal	750	1 250	1 100	950	950	5 000
Total	1 750	2 250	2 100	1 950	1 950	10 000

Preparation process

19. The preparation of the new country programme was based on the major problems identified in the situation analysis; the provisions of the Convention on the Rights of the Child; and the goals of the NPA. The new country programme period is also synchronized with the cycles of cooperation between the Government, the United Nations Development Programme (UNDP) and the United Nations Population Fund (UNFPA), starting in 1996. The country strategy note for Government cooperation with United Nations agencies was used as a reference so that UNICEF cooperation is complementary to that of other United Nations agencies.

Objectives and strategies

20. The proposed country programme will build on the past programme of cooperation and aims to (a) promote reform of the PHC system; (b) strengthen the foundation for achieving and sustaining the decade goals; (c) expand initiatives for safe motherhood; and (d) build local capacity more systematically to reduce gaps in access to and coverage of basic services.

21. UNICEF cooperation will contribute to the achievement of the following goals related to the NPA and the Declaration of the World Summit for Children: (a) reduction of IMR from 34 to 22 per 1,000 live births; (b) reduction of U5MR from 41 to 30 per 1,000 live births; (c) reduction of MMR from 140 to less than 70 per 100,000 live births; (d) elimination of malnutrition and reduction of

moderate malnutrition among children under five years of age by one half; (e) empowerment of families with the basic knowledge, skills and values needed to improve the quality of their life; and (f) to sustain achievement of mid-decade goals.

22. The programme will be implemented at three levels: national; area-based; and cross-cutting. The national programmes aim to improve the quality of and sustain basic services, e.g., for health and education. The area-based programme addresses inequities through decentralized implementation and sharper targeting of national programmes to reach the 20 per cent of the population who are underserved. Cross-cutting interventions link all elements of the country programme by strengthening public consensus and communication initiatives for achieving the decade goals.

23. Strategies for strengthening the impact of the cooperation include empowering families with basic knowledge, skills and values needed for healthy living; local capacity-building to improve response to local needs; improving the role and status of women within the family and the community; increased resources, particularly for underserved areas; advocacy and research to keep the needs of children and women high on the political agenda; and strengthening the sustainability of all programmes.

Health

24. The health programme will support PHC reform, safe motherhood, CDD, the control of ARI and EPI. The aims are to sustain the gains of EPI and CDD and to accelerate the progress in safe motherhood and the control of ARI.

25. PHC reform will address major management problems that constrain quality and sustainability of services. The strategy will improve performance of health staff through pre-service and in-service training on team work in the delivery of MCH services. Another initiative will strengthen communication between communities and the PHC system, especially in high-risk areas. UNICEF will support policy advocacy for standardization of service norms; the organization of joint workshops; and the provision of technical and material support to governorate- and district-level health authorities. Supplementary funds will be used to increase integration and coordination of service delivery, particularly in high-risk areas.

26. In the area of safe motherhood, the priority will be to improve the quality of MCH services so as to increase utilization, especially in rural and poor urban areas. UNICEF will support in-service training of 800 health staff; 15 communication campaigns to increase maternal demand for MCH care; education for girls and women on fertility and MCH; promotion of birth spacing, safe delivery, and antenatal care; improved monitoring and referral systems; and basic supplies and equipment for the establishment of obstetrical services in 60 MCH centres. Advocacy will focus on decentralization of MCH care and improved training of health staff. Supplementary funds will be used to promote integrated delivery of all safe motherhood activities.

27. The objectives in CDD are to increase the number of health centres with ORT corners from 10 per cent in 1993 to 50 per cent by 1996; to increase the number of health staff trained in correct case management from 30 per cent in 1993 to 70 per cent; to raise the ORT usage rate from 62 per cent in 1990 to 90 per cent in 1996; and to strengthen continued breast-feeding during diarrhoea from 68 per cent in 1990 to 95 per cent in 1997. UNICEF will support the development of a comprehensive national policy on CDD; the training of 350 health workers and 200 medical staff in correct case management; the production and dissemination of information, education and communication (IEC) materials to promote continued breast-feeding and the use of ORT; and the provision of supplies and equipment for ORT corners. Supplementary funds are needed to

strengthen public awareness on the prevention of diarrhoeal diseases and to accelerate the training of health and medical staff, especially in rural and poor urban areas.

28. Another important aim is to reduce ARI-related mortality and morbidity among infants and children under five years of age from 10.5 per cent mortality and 30 per cent morbidity in 1990 by 50 per cent and 25 per cent, respectively. UNICEF will provide technical assistance for the establishment of an ARI training unit and for training materials; the production of diagnostic charts, slides, video tapes, posters and pamphlets; the training and retraining of 18 governorate trainers; on-the-job training of 800 health staff and 1,200 doctors; the provision of equipment for diagnosis and case management; strengthening routine reporting; and the establishment of sentinel reporting networks at both public and private hospitals. Supplementary funds will be used for the provision of training materials and for accelerating the training and retraining of health staff.

29. Immunization coverage will be increased in all districts to 95 per cent by 1998, and poliomyelitis will be eradicated by the year 2000. UNICEF will provide technical assistance and materials for training medical and paramedical staff in surveillance; seminars and workshops on surveillance; strengthening of sentinel reporting systems; identification and mapping of high-risk areas; and detection of cases and surveys on neonatal tetanus protection at birth and other relevant studies. Supplementary funds will be used to strengthen the surveillance and reporting systems.

Nutrition

30. Nutrition will focus on improving child feeding practices and reducing malnutrition. The child feeding initiative will promote more conducive social environments for breast-feeding and growth promotion. UNICEF will assist advocacy/awareness-raising, training of 550 health staff, monitoring and evaluation. The control of malnutrition will focus on reducing iron deficiency anaemia among pregnant women from 40 per cent in 1990 to 15 per cent; eliminating severe malnutrition; reducing moderate malnutrition from 6 per cent in 1993 to 3 per cent; reducing the incidence of low birth weight from 11 per cent in 1990 to 6 per cent; increasing growth monitoring activities from 15 per cent in 1990 to at least 50 per cent; and sustaining the elimination of IDD and vitamin A deficiency. UNICEF will support the iodization of salt; the development of a methodology for assessing the iodine content of salt at production sites and markets; legislation on IDD; public awareness campaigns; the promotion of interministerial coordination for IDD; the training of health staff; and monitoring and evaluation. Supplementary funds will be used to accelerate growth monitoring and promotion through increasing public awareness.

Education

31. UNICEF cooperation in education will cover ECD, primary education and life skills education for women. Government efforts to achieve the education goals of the NPA nationwide will be supported by improving the quality of and access to pre-schools and primary schools and adult literacy programmes.

32. In the area of ECD, the programme aims to reach at least 75 per cent of children of working mothers, improve knowledge and skills of care givers and raise mothers' knowledge and life skills for ECD. Cooperation on primary education aims to sustain universal primary school enrolment and achieve the target in every district; increase primary school completion to 95 per cent; and reduce the primary school drop-out rate by two thirds, with priority on girls. Development of a more student-centred classroom environment and a curriculum more focused on life skills will be priorities. Linkages between the education and health programmes will make the curriculum more relevant to the needs of the community. UNICEF will support the production of teaching/learning modules;

train 300 primary school teachers from poor areas; help to improve sanitation/hygiene services in rural primary schools; upgrade the education database; assess/monitor learning achievement; sponsor surveys on repetition and school drop-outs; promote the nutrition status of schoolchildren; and promote education for disabled schoolchildren. Supplementary funds will be used to increase access to ECD and to improve the quality and relevance of pre-school and primary school education.

33. The project on basic life skills for women will increase vocational and income-generating skills of poor women by utilizing the national women's literacy programme to empower them with key knowledge and skills. Innovative learning materials will be developed and introduced through the training of literacy teachers. Supplementary funds will be used for development of innovative learning materials.

High-risk, area-based programme

34. The programme will address the problems of inequity, over-centralization and inequitable resource allocations by targeting assistance to high-risk areas and by promoting local capacity-building; increased community decision-making in programme planning and implementation; and improving linkages between central, governorate and local levels so that basic services become more coordinated during delivery and responsive to local needs and sustainable. The first phase of the programme will address the squatter settlements around Damascus, followed by expansion to reach to the rural northern Aleppo governorate; some 2 million persons will be covered. The Government, the community and non-governmental organizations (NGOs) jointly will identify local needs and goals and develop and implement plans. UNICEF will support programme planning; capacity-building through training local staff; girls' education; MCH; and improved water supply and sanitation. Supplementary funds are needed to adapt national programmes to meet local needs.

Advocacy and social mobilization programme

35. This programme will promote increased national resource allocation for programmes related to implementation of the Convention on the Rights of the Child and the Convention for Elimination of All Forms of Discrimination Against Women and to accelerate achievement of NPA goals. The strategy is to strengthen all advocacy and social mobilization elements of the country programme through more effective communications strategies. UNICEF will support IEC activities to promote formulation of appropriate policies related to the two Conventions and the NPA. UNICEF will also support ways to strengthen the participation of NGOs; improve coordination of the public and private sectors and NGO efforts; provide orientation of media personnel; provide training materials; and strengthen monitoring and evaluation. Supplementary funds will be used to promote the integration and coordination in service delivery.

36. The communication components of the health, education and area-based programmes will be strengthened to generate more support from the donor community, mass media, NGOs and research institutions. The intensification of communication activities will be possible with supplementary funds.

Monitoring and evaluation

37. Annual project plans of action with service coverage and output objectives will facilitate monitoring programme implementation. Progress towards achieving objectives will be monitored through routine reporting, sentinel surveillance and rapid and specialized surveys and studies. Household health surveys will analyse caregiver knowledge, attitudes and practices. Health facility surveys will review treatment protocols and case management. UNICEF will provide

technical assistance and the training of staff to build national capacity in monitoring. Joint UNICEF/Government annual programme reviews will help to adjust programmes to respond to challenges.

Cooperation with other parties

38. The programme will be implemented in close coordination with other United Nations agencies. Cooperation with the UNFPA will focus on safe motherhood and population activities. With the World Health Organization the focus will be on EPI, CDD and the control of ARI and micronutrient deficiencies. Cooperation between UNICEF and UNDP in human resource development and poverty alleviation will continue, particularly for underserved areas.

Programme management

39. The responsibilities of one UNICEF programme officer will be modified to focus on the area-based programme. Other programme officers will also contribute to the area-based programme in line with their respective responsibilities. The importance of social mobilization and communication in the new period of cooperation and strengthening computerization for information resource management in the UNICEF office in Damascus will receive attention.